DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1174 (10/01)

STATE OF WISCONSIN
HFS 106.13, 105.17(2)(b)(3), 107.112 (3)(c)

WISCONSIN MEDICAID
MEDICAL PROFESSIONAL STATEMENT IN SUPPORT OF REQUEST FOR VARIANCE OF 60-DAY SUPERVISORY VISIT REQUIREMENT

Before completing this form, read the statement on the reverse side.

Personal Care Agency Name	Personal Care Agency Telephone Number

Personal Care Agency Address (Street, City, Zip Code)

Subcontracted Personal Care Agency (if applicable)

Medicaid Recipient's Name	Recipient's Medicaid Identification Number

1. In my professional judgment, this recipient does not require a supervisory home visit by a registered nurse (RN) supervisor every 60 days.
2. The frequency of supervisory home visits by an RN supervisor under the variance is specified in the plan of care (attached). (Period may not exceed 365 days.) I have read the updated, attached plan of care and I agree with the period between RN visits indicated.
3. The variance in frequency of visits will not adversely affect the health, safety, or welfare of the recipient.
4. The findings indicated above are based upon such examinations, reviews and/or other inquiries as I find to be necessary and appropriate within my professional judgment.
5. I will monitor the recipient's condition as I find to be necessary and appropriate to determine whether the frequency of RN visits should be changed.
6. I will continue to follow the Medicaid requirements not affected by this variance, as defined in the Medicaid administrative rules.
7. The recipient has been instructed how to get in touch with me for routine matters or in case of an emergency.
8. I will change the plan of care or sign a medical order increasing the frequency of RN visits if I feel that the recipient requires more visits than specified in the plan of care.

SIGNATURE — Recipient's Physician*	Date Signed
SIGNATURE — RN Supervisor	Date Signed

* The physician who signed written orders for the recipient's personal care.

Retain a copy of this form for your records.

Submit this completed and signed form with a completed and signed "Recipient Request for Variance of 60-Day Supervisory Visit Requirement" and an updated plan of care to:

Wisconsin Medicaid
Prior Authorization
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Reset Form

Wisconsin Medicaid requires specific information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02 [4], Wis. Admin. Code).

Under s. 49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for these services.

This form is authorized under HFS 106.13, Wis. Admin. Code. Completion of this form is mandatory to obtain a variance from Wisconsin Medicaid's 60-day registered nurse (RN) visit requirement under s. HFS 105.17(2)(b)(3) and 107.112(3)(c), Wis. Admin. Code, such that visits may be made less often than every 60 days. The variance may be granted only to personal care-only agencies, not home health agencies.